

ALLERGIES AND MEDICATION
(To be filled out by parent)

Name: _____

Date: _____

Food Allergies:

Is child allergic to any foods? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Medical Allergies:

Is child allergic to any medicines? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Current Medical Status:

Does child have any important medical problems?

Please describe: _____

Please name doctor caring for this: _____

Is child receiving medication of any sort? Yes __ No __

If yes:

Medication (s) _____ dose _____ time _____ Doctor _____

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